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March 13, 2006

DEPARTMENT OF ENERGY
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Name of Case: Personnel Security Hearing

Date of Filing: October 26, 2005

Case Number: TSO-0303

This Decision considers the eligibility of XXXXXXX XXXXXXX (hereinafter referred to as "the individual") to hold an access authorization under the regulations set forth at 10 C.F.R. Part 710, entitled "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." As explained below, it is my decision that the individual's access authorization should be restored.

I. *BACKGROUND*

The individual is an employee of a Department of Energy (DOE) contractor, and has held a DOE access authorization continuously since 1973. Incident reports received by the DOE indicated that the individual was hospitalized for psychiatric care in 1980, May 1996 and January 1997. In a June 2004 incident report, the individual stated that he was again hospitalized for psychiatric care. The DOE conducted a personnel security interview with the individual in December 2004 (the 2004 PSI). In March 2005, a DOE-consultant Psychiatrist conducted a psychiatric evaluation of the individual. The DOE-consultant Psychiatrist issued a psychiatric evaluation report on March 5, 2005 and an amended evaluation report on May 10, 2005.

In August 2005, the Manager for Personnel Security of the DOE area office where the individual is employed (the Manager) issued a Notification Letter to the individual. The Notification Letter states that the individual's conduct has raised a security concern under Sections 710.8(h) of the regulations governing eligibility for access to classified material. With respect to Criterion (h), the Notification Letter finds that the individual was evaluated by the

DOE-consultant Psychiatrist in 2005, and it is the DOE-consultant Psychiatrist's opinion that the individual meets the Diagnostic and Statistical Manual of the American Psychiatric Association, IVth Edition, Test Revision (DSM-IV TR) criteria for Bipolar Disorder, Type I. The Notification letter states that the DOE-consultant Psychiatrist concluded in his amended evaluation report that the individual has an illness or mental condition of a nature which causes, or may cause, a significant defect in his judgment or reliability. Additionally, he found that the nature of this disorder is that it continues to cycle from mixed or manic episodes to remissions without symptoms and may also cycle to depressive episodes; and that it is more likely than not that the individual will suffer additional psychotic episodes in the future.

The Notification Letter also states that during the 2004 PSI, the individual admitted to being hospitalized in June 2004 with problems of psychosis, and that he was discharged with a diagnosis of Bipolar Disorder. It further states that the individual indicated that he was hospitalized in January 1997 for Major Depressive Disorder, recurrent, with psychotic features, and that he was hospitalized in May 1996 for psychosis not otherwise specified, and depression. Finally, the Notification Letter states that the individual has reported that the was hospitalized in January 1981 for three days of detoxification from alcohol and for three days in 1980 for detoxification, depression and for threatening suicide.

The individual requested a hearing to respond to the security concerns raised in the Notification Letter. In his response to the Notification Letter and in subsequent filings, the individual contested the DOE-consultant Psychiatrist's conclusion that he has a mental condition that causes or may cause a significant defect in his judgment and reliability. He asserts that recent medical evidence indicates that he has no current psychiatric symptoms, and that his course of treatment has been effective. He also asserted that the 1981 and 1980 hospitalizations listed in the Notification letter did not take place, and that he was hospitalized once in the late 1970's for three days of alcohol detoxification.

The hearing was convened in January 2006 (hereinafter the "Hearing"), and the testimony focused on the concerns raised by the DOE-consultant Psychiatrist's diagnosis and the individual's efforts to mitigate those concerns.

II. *REGULATORY STANDARD*

In order to frame my analysis, I believe that it will be useful to discuss briefly the respective requirements imposed by 10 C.F.R. Part 710 upon the individual and the Hearing Officer. As discussed below, Part 710 clearly places upon the individual the responsibility to bring forth persuasive evidence concerning his eligibility for access authorization, and requires the Hearing Officer to base all findings relevant to this eligibility upon a convincing level of evidence. 10 C.F.R. §§ 710.21(b)(6) and 710.27(b), (c) and (d).

A. *The Individual's Burden of Proof*

It is important to bear in mind that a DOE administrative review proceeding under this Part is not a criminal matter, where the government would have the burden of proving the defendant guilty beyond a reasonable doubt. The standard in this proceeding places the burden of proof on the individual. It is designed to protect national security interests. The hearing is "for the purpose of affording the individual an opportunity of supporting his eligibility for access authorization." 10 C.F.R. § 710.21(b)(6). The individual must come forward at the hearing with evidence to convince the DOE that restoring his access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.27(d). *Personnel Security Review (Case No. VSA-0087)*, 26 DOE ¶ 83,001 (1996); *Personnel Security Hearing (Case No. VSO-0061)*, 25 DOE ¶ 82,791 (1996), *aff'd*, *Personnel Security Review (VSA-0061)*, 25 DOE ¶ 83,015 (1996). The individual therefore is afforded a full opportunity to present evidence supporting his eligibility for an access authorization. The regulations at Part 710 are drafted so as to permit the introduction of a very broad range of evidence at personnel security hearings. Even appropriate hearsay evidence may be admitted. 10 C.F.R. § 710.26(h). Thus, by regulation and through our own case law, an individual is afforded the utmost latitude in the presentation of evidence which could mitigate security concerns.

Nevertheless, the evidentiary burden for the individual is not an easy one to sustain. The regulatory standard implies that there is a presumption against granting or restoring a security clearance. *See Department of Navy v. Egan*, 484 U.S. 518, 531 (1988) ("clearly consistent with the national interest" standard for the granting of security clearances indicates "that security determinations should

err, if they must, on the side of denials"); *Dorfmont v. Brown*, 913 F.2d 1399, 1403 (9th Cir. 1990), *cert. denied*, 499 U.S. 905 (1991) (strong presumption against the issuance of a security clearance). Consequently, it is necessary and appropriate to place the burden of persuasion on the individual in cases involving national security issues. In addition to his own testimony, we generally expect the individual in these cases to bring forward witness testimony and/or other evidence which, taken together, is sufficient to persuade the Hearing Officer that restoring access authorization is clearly consistent with the national interest. *Personnel Security Hearing (Case No. VSO-0002)*, 24 DOE ¶ 82,752 (1995); *Personnel Security Hearing (Case No. VSO-0038)*, 25 DOE ¶ 82,769 (1995) (individual failed to meet his burden of coming forward with evidence to show that he was rehabilitated and reformed from alcohol dependence).

B. *Basis for the Hearing Officer's Decision*

In personnel security cases under Part 710, it is my role as the Hearing Officer to issue a decision as to whether granting an access authorization would not endanger the common defense and security and would be clearly consistent with the national interest. 10 C.F.R. § 710.27(a). Part 710 generally provides that "[t]he decision as to access authorization is a comprehensive, common-sense judgment, made after consideration of all relevant information, favorable and unfavorable, as to whether the granting or continuation of access authorization will not endanger the common defense and security and is clearly consistent with the national interest." 10 C.F.R. § 710.7(a). I must examine the evidence in light of these requirements, and assess the credibility and demeanor of the witnesses who gave testimony at the hearing.

III. *HEARING TESTIMONY*

At the Hearing, testimony was received from seven persons. The DOE presented the testimony of the DOE-consultant Psychiatrist, who testified at the conclusion of the Hearing. The individual testified and presented the testimony of his wife, his step-daughter, a friend, a co-worker, and his psychiatrist. 1/

1/ As indicated by the Curriculum Vitae of the DOE-consultant Psychiatrist, and by the Curriculum Vitae and the testimony of the individual's psychiatrist (Hearing Transcript, "TR", at 139-140), they both have extensive clinical experience in

(continued...)

A. *The Individual*

In his testimony at the Hearing, the individual testified that he has been employed as a contract employee at what is now a DOE facility since 1968. He stated that he has had three significant hospitalizations during this period, in May 1996, January 1997, and June 2004. TR at 94. He stated that his psychiatrist first began treating him during his May 1996 hospitalization. TR Id. He stated that his wife took him to the hospital because he had not slept in three days and she told him that he was not acting right. He stated that she spoke to his regular doctor, who suggested that she take him to a local psychiatric hospital. He stated that when he tried to leave the hospital, he was forcibly detained by guards and involuntarily committed. After eight days of hospitalization, he was released and went right back to work. TR 96.

He stated that the following the May 1996 hospitalization, he began seeing his psychiatrist on a regular basis, who was prescribing medication. He stated that his second hospitalization took place after he reported to his psychiatrist that the word "kill" kept coming into his head when he was around loved ones, specifically his wife and his dog. TR at 97 and 116. He denied that he had any urges to act violently but that he was bothered that the word "kept popping in my head." TR at 97. He stated that he stayed in the hospital for about five days in January 1997, and then took a week off before returning to work. *Id.* He stated that he has never been bothered by the word "kill" or anything like that entering his head while he was at work. He testified that he has no conflicts with any of his co-workers or supervisors. TR at 98.

With regard to his June 2004 hospitalization, the individual reported that he was having trouble concentrating at work and then became upset by a religious book that he was reading. He stated that he left work early and went for a drive. Although he did not hear any voices, he felt that God was calling him to start a church in a nearby community. TR at 103. He stated that he told his wife about his idea to start a church, and that she thought that the idea "wasn't right" so she talked to their minister. TR at 118-119. He testified that that night, he went for a long drive.

1/(...continued)
diagnosing and treating mental illnesses. They clearly qualify as expert witnesses in this area.

> The next day after I drove around all night – I left in the middle of the night and drove around. I came back about 11:00 [a.m.] the next day and waited for my wife to get home. She got home, I don't know, about 1:00, and she talked to me a little bit, and she thought something was wrong.

TR at 121. After his wife spoke to the individual's psychiatrist, she drove him to the psychiatric hospital. TR at 123. During this hospitalization, the individual's psychiatrist told him that he thought that the individual was bipolar. *Id.*

The individual testified that after his 1996 hospitalization, he was prescribed Paxil, but did not believe that it was helping him much. TR at 115. After his 1997 hospitalization, he began to take Prozac, Trazodone and Klonopin. TR at 117. After his 2004 hospitalization, he began taking Depakote and Seroquel along with Prozac, and stated that his mood and his concentration have improved. TR at 124.

The individual stated that he and his wife live on a small farm several miles from the DOE facility. He testified that he usually gets up around 6:30 a.m., drinks a cup or two of coffee, watches a little television, and drives to work. He reported that he tries

> to do the best job I can while I'm there. I think I'm well liked by all my co-workers.

TR at 99. He stated that his shift ends at about 4:00 p.m., and that he then returns home and takes care of the farm animals. TR at 100. He stated that he has a close relationship with his wife, is confident that she has his best interests at heart, and that he has never refused to act on her suggestions to get treatment for bipolar symptoms. TR at 105. He stated that his wife is aware that he takes medication, and occasionally reminds him to take his nightly dosage. TR at 107.

He testified that he is on good terms with other family members, but that his family lives in another state, and that his wife's grown children live thirty or more miles away. TR at 108.

The individual stated that he had problems with alcohol until the early 1980's, when he gave up alcohol entirely for several years. TR at 104. He testified that in recent years he consumes alcohol on rare occasions and that his last alcoholic drink was a beer that he consumed more than two years ago. *Id.*

The individual testified that he has seen his psychiatrist on a monthly basis since his 2004 hospitalization, and that he knows that he could make additional appointments at any time. TR at 105-106.

B. *The Individual's Wife*.

The individual's wife testified that she first met the individual in 1983 and that they were married in 1987. She states the individual has stopped drinking alcohol before they met, and that she strongly supports his sobriety. TR at 61-62. She testified that their relationship is centered around their home life.

> We're homebodies. We live in the country, and we've got our animals, and we're always busy with the cows or something. You know, we got the neighbors that we have to help them load up cows and vaccinate them and stuff, and then they help us. . . . We're not socializers outside the home. We're just more or less at home.

TR at 62-63. She stated that her daughters and their families visit regularly, and that she and her husband are active church members. She added that the individual is on a church committee involved with building repairs and maintenance. TR at 63-64. She stated that in the evenings, they always eat dinner and watch television together. TR at 65-66.

The individual's wife testified that nothing in her husband's behavior has ever given her cause for concern about her safety, and that he has never communicated to her about having any unusual problems or stresses in the workplace. TR at 60-61.

With regard to the individual's hospitalizations, the individual's wife stated that she has never had any trouble persuading him to go to the hospital. TR at 70. She stated that she has suggested to the individual that he's been acting strangely and has urged him to get medical attention.

> I'll tell him if I think he might be a little off the wall or something. Then I'll say "I think that maybe you ought to get ahold of [the individual's psychiatrist]." He's been his doctor now from the very beginning.

TR at 75. She stated that other than the stress arising from the issue of his access authorization, there are no major stresses in their daily lives. TR at 76.

The individual's wife recalled that at the time of his 1996 hospitalization, the individual was nervous, unable to get anything done, and unable to sleep. TR at 79. She recalled that he had to be restrained at the hospital. TR at 81. She could not recall the individual's hospitalization in January 1997. *Id*. She stated that his June 2004 hospitalization was prompted by his sleeplessness. TR at 82. She stated that when he got back from his car ride, she said "I think we ought to get ahold of [the individual's psychiatrist]" but that the individual said "let's just go ahead on to the hospital" and that she called the individual's psychiatrist on the way. TR at 91.

She stated that she is aware that the individual takes medication in the mornings and evenings, but that he is in charge of his medication and does not need reminding. TR at 83. The individual's wife said that she's never had a "one-on-one" with the individual's psychiatrist about her husband's mental illness, and that he has given her no directives for her husband's treatment. TR at 87.

After hearing the testimony of the DOE-consultant Psychiatrist and the individual's psychiatrist, the individual's wife stated that she had a better understanding of the individual's diagnosis of bipolar disease and that she would like to educate herself more on it. TR at 210-211. She also stated that she was in a position to notice changes in the individual's sleep patterns and his mental state, and that she would be able to report such changes. TR at 211.

C. *The Individual's Daughter-in-Law*

The individual's daughter-in-law testified that she has known the individual since she was sixteen, which is more than twenty years. TR at 38. She stated that during this time she has often resided in the same vicinity as the individual, and now lives approximately thirty minutes away by car. TR at 38-39. She testified that she has never had any concern for the safety of herself, her children and her stepchildren in being around the individual and has occasionally left her children and step children in the care of the individual and his wife. TR at 39. She stated that she was aware that the individual has had some hospitalizations as a result of mental problems but that she has no first hand experience of his bipolar episodes and hospitalizations. She stated that the individual always has appeared normal and friendly in his interactions with her. TR at 42-47. She stated that he has been supportive of her over the years and she feels safe with him. TR at 52. She stated that she has never seen him drink alcohol to excess. TR at 54. She stated that her mother had never seemed

scared of the individual, and that she learned of his hospitalizations from her mother after they took place. TR at 55-56. She stated that the individual and her mother do not appear to need any special support from her, and that she sees them at family holidays and on a few other occasions during the year. TR at 57-58.

D. *The Individual's Friend*

The individual's friend testified that he has known the individual for about 21 years. He said that he became friendly with the individual when they were neighbors for about nine years, and that he maintained contact with the individual and his wife when they moved to their current home, which is about four or five miles away from his home. TR at 25-26. He stated that he presently sees the individual about two or three times a week.

> He's just like any of my friends. He helps me do stuff. He's helped me do a lot of work on my cars. He's helped me with my house. I go over [to their house] and hang out. Sometimes they come over to my house. We'll watch a movie. Just normal that you would do with any of your friends.

TR at 27. He stated that he was aware from listening to the individual and his wife converse that the individual had had some issues with depression since the 1990's but that he "figured it was none of my business." TR at 26-27. He stated that he never had a concern for his safety or security around the individual, and that he had never witnessed the individual behaving in a bizarre or unusual manner. TR at 27-28 and 33. He stated that the individual and his wife spend time taking care of the goats, horses and cows on their farm, and also have dogs and cats. TR at 28-29. He stated that he has been on fishing trips with the individual, and that they frequently dine out at restaurants. He stated that he does not consume alcohol and that he has never observed the individual consume alcohol. TR at 29-30. He stated that he was aware that the individual was hospitalized "three or four" times in recent years, but that he does not know anything about those hospitalizations. TR at 34-35.

E. *The Individual's Co-Worker*

The individual's co-worker testified that he has worked at the same DOE facility as the individual since 1977. TR at 13. He stated that he and the individual worked "the third shift" together "25-plus years ago" and at that time he and the individual would

occasionally have a couple of beers together. TR at 15-16. He stated that he no longer socializes with the individual except at occasional union meetings. He does not believe that the individual is currently consuming alcohol. TR at 16. He testified that since 1997, he and the individual have been working fairly closely together at the DOE facility. He stated that the individual's appeared to tolerate frustration appropriately and never displayed inappropriate behavior. TR at 17. He described the individual's behavior as

> Well, normal. He was professional. He did a good job, he was considerate and conscientious.

TR at 17. The individual's co-worker stated that the individual had informed him that he was on medication and that he had been hospitalized twice. TR at 20. He also had been aware that the individual had been on medical leave from his job. *Id.* He stated that the individual has seemed rational and level-headed in all of their interactions. TR at 21.

F. *The Individual's Psychiatrist*

The individual's psychiatrist testified that he first treated the individual when he was brought to the psychiatric hospital in 1996.

> At that time he had a psychotic episode and was delusional and was brought to the hospital by family, I believe, at that time. I think he was admitted by one of my partners, who transferred him to me the next day.

TR at 144. He stated that he could not tell, from reviewing the chart, if the individual was ever detained as an involuntary admission.

> That might have been the case, but if it was, it was very briefly, because I recall that was in the context of an event in which there might have been a pushing of another patient and some intervention of staff was required at that time, but I don't recall that [the individual] was particularly resistant to being in the hospital.

Id. The individual's psychiatrist stated that the individual has been cooperative throughout his treatment. TR at 145. He stated that during the individual's 1996 hospitalization he was treated for a depressive episode, but that in retrospect, it clearly was part of an evolving bipolar condition. TR at 145. He stated that he

agreed with the diagnosis made by the DOE-consultant Psychiatrist, and that nothing in the DOE-consultant Psychiatrist's evaluation of the individual stands out in his memory as being totally incorrect. TR at 164.

He stated that the individual's psychotic symptoms included some paranoid thinking, but generally delusional thinking with a significant religious element. TR at 146. He stated that the individual's 1997 hospitalization arose from a psychotic episode involving an obsessive-intrusive type of thought, *i.e.* the word "kill", as opposed to a hallucination.

> Clearly, it was in the context, again, of a psychotic episode, but what he also described was that he had no plans and intentions to act on that thought or that word and, in fact, felt repulsed by it, that that was something he would not want to do.

TR at 147. He stated that the individual and he have a good therapeutic relationship.

> I think [the individual] is very open and honest. He's a patient who has stood out, let's say, over the years as being a person who keeps his appointments, who has been cooperative, who, I think, has been an honest and straightforward person, as nearly as I can tell.

TR at 151.

The individual's psychiatrist testified that the nature of the individual's bipolar disorder is that it is recurrent, and that the individual, "through no fault of his," is at risk for future episodes. TR at 152-153. He stated that the individual's illness is in remission and characterized the likelihood of recurrence as follows:

> . . . with the exception of the '96 to '97 interval, which, really was at a relatively early point diagnostically for him, and in the evolution of his disorder, with that exception, he's had significant periods of time of essentially being in remission.

TR at 154. He stated that the individual's episodes appear to have more of a biological than a situational origin.

> I don't think, for [the individual] that there has been a history that suggests that there have been particular psychological or situational stresses that have triggered these episodes.

TR at 156. He stated that there is nothing about the individual's condition that would lead him to think that the individual would compromise security in his workplace or pose a danger to others in the workplace or elsewhere. TR at 158-159. He stated that he believed that he was able to continue treating the individual for bipolar disorder and to manage his condition medically. TR at 159. He testified that the individual currently takes Depakote, Prozac, and Seroquel, an antipsychotic. He stated that he is in the process of having the individual taper off of Seroquel, but that he believes the individual should continue to take Depakote and Prozac.

> In the absence of evidence to the contrary, I think that it is riskier to make a change at this point for [the individual], from the standpoint of switching him to something totally different, than to continue with the basic foundation medications.

TR at 174.

He stated that he did not believe that the individual's history indicated that his heavy consumption of caffeine served as a trigger for his psychotic episodes, but agreed that the individual's caffeine consumption requires ongoing assessment and monitoring. TR at 164-165.

The individual's psychiatrist stated that the individual exercised good judgment in 2004 when his wife encouraged him to go to the hospital. TR at 161. He stated that although the individual's wife does not closely monitor the individual's medication, she has supported the individual's treatment by noticing changes in the individual's behavior.

> I think she's a person who has gotten involved when she's seen changes in behavior and has called me at those times to express concerns. I think that that's a very important part of monitoring, a person who knows the person saying they are not doing well.

TR at 169. After listening to the DOE-consultant Psychiatrist's comments at the Hearing that the individual and his wife are not sufficiently educated in the symptoms of bipolar disorder and are

not adequately monitoring the individual's behavior for signs of an oncoming episode, the individual's psychiatrist stated that he would meet with the individual and his wife to set up a specific monitoring plan. TR at 214. In a letter dated February 23, 2006 to the individual's counsel, the individual's psychiatrist reported that he met with the individual and his wife and implemented a monitoring plan.

> [The individual] is to keep a daily log of mood rated on a scale from one to ten, and also to keep a log of hours asleep. I have given him specific rating instructions regarding a one to ten-scale, and indicated to both he and his wife that should he experience any sleepless or near sleepless nights, or two consecutive nights of six hours sleep or less, that I am to be immediately contacted. Both understood my instructions and indicated that they would comply with contacting me. [The individual] is scheduled to see me once again in two to three weeks, and his wife will accompany him to that appointment as well.

February 23, 2006 letter. The individual's psychiatrist also stated in this letter that he has added Lamictal to the individual's daily medications and that the individual appears to be doing well with respect to his mood disorder. He stated that there currently are

> no psychotic features and no safety issues, specifically no thoughts of [the individual] harming himself or others.

Id.

G. *The DOE-consultant Psychiatrist*

The DOE-consultant Psychiatrist testified that when he evaluated the individual, he diagnosed him with bipolar disorder type I, mixed, that at times becomes severe with psychotic features, and with alcoholism in full remission. After listening to the testimony of the individual and his witnesses, the DOE-consultant Psychiatrist stated that he would not change his earlier diagnoses, and that the alcoholism and the bipolar condition both remain in full remission. TR at 182-183.

The DOE-consultant Psychiatrist stated that he deals with bipolar patients as a specialty, and that it is a very difficult disease. He stated that it is a disorder that can cause psychotic behavior

accompanied by a lack of acknowledgment or recognition that symptoms are going on. TR at 184. He stated that the key to good treatment is to manage recurrences and give a patient the best chance of reducing further episodes. He testified that a bipolar patient and his family should be educated to recognize the first symptoms of a bipolar episode. In particular,

> the first night there is a lack of sleep, that's got to ring bells with the family that one lives with as well as the patient.

TR at 185. He testified that although the testimony of the individual's wife and stepdaughter indicated that they "are overall extremely supportive" of the individual, they should understand the disorder better and be able to react immediately to notify the individual's doctor if the individual developed an inability to concentrate, or expressed delusional thoughts, or stayed up at night. TR at 186.

The DOE-consultant Psychiatrist also stated that he agreed with the individual's psychiatrist that caffeine consumption by the individual was not a specific causative factor in triggering his bipolar episodes. However, he added that caffeine could be a contributing factor to the episodes and that the individual's psychiatrist should have more concern about the individual's consumption of coffee. TR at 186-187. The DOE-consultant Psychiatrist agreed that the individual's consumption of a couple of beers in 2003 was not a cause for concern, but that the individual needed to have more open communication with his psychiatrist and his family so that they can identify issues of real concern. TR at 187-188.

The DOE-consultant Psychiatrist stated that he disagreed with the individual's psychiatrist's treatment of the individual with an antidepressant. He stated that antidepressants

> increase the rate of cycling [of bipolar episodes] and in about ten percent of cases, it can flip a patient into mania from depression. There is a reasonably strong consensus that they are not used, despite a bipolar patient spending most of their time in depression. At least my understanding is you treat more with mood stabilizers.

TR at 188.

The DOE-consultant Psychiatrist stated that he agreed with the individual's psychiatrist that it is "very, very difficult" to estimate the likelihood that the individual will relapse within the next year.

> My guess is that [the individual] has had three, in my opinion, very, very clear episodes of mixed bipolar, and I suspect that the earlier [hospitalization] in the '80's, although overshadowed by alcoholism, was another episode. He's gone a couple of years without an episode, but he is clearly at a much higher risk than the average guy on the street to have another episode.

TR at 189-190. He further stated that the individual's chances were "high medium" to have another episode sometime in the next three years. TR at 190. He stated that he was "uncomfortable" speaking to the security risk posed by the individual's bipolar illness, but stated that he believed that more could be done by the individual and his family to identify the initial symptoms of a bipolar episode. He stated that

> What comes to mind is a daily mood rating scale which scales hours of sleep the night before. That's a very useful instrument for catching initial onsets.

TR at 207. The DOE-consultant Psychiatrist stated that he requires his bipolar patients to

> take 30, 40 seconds a day and score their mood and their sleep, and that they bring that in each time that I see them.

TR at 212.

As discussed above, the individual's psychiatrist and the individual have acted to implement these suggestions. After reviewing the individual's psychiatrist's February 23, 2006 letter discussing his program for the individual, the DOE-consultant Psychiatrist commented as follows:

> [The individual's psychiatrist's] additional precautions are appropriate and enhance the chances of detecting a future psychotic, manic episode sooner rather than later. Additional steps taken by [the individual's psychiatrist] include: seeing [the individual] every three weeks instead of every three months, involving his wife in

identifying early symptoms, and additional focus on lack of sleep.

March 6, 2006 email from the DOE-consultant Psychiatrist to the Hearing Officer. The DOE-consultant Psychiatrist stated that he continued to disagree with the individual's psychiatrist's decision to continue to prescribe an anti-depressant or an anti-psychotic to the individual. However, he also stated that he acknowledged that "there are differing opinions in the field." *Id.*

IV. *ANALYSIS*

Through his counsel and in his testimony at the Hearing, the individual admits that his history of hospitalizations for psychotic, manic episodes and his diagnosis of "Bipolar Disorder, Type I, Mixed" indicate an ongoing mental condition that carries the risk of future psychotic episodes. However, the individual argues that the management of his disease indicates that the security risk associated with a future psychotic episode is reasonably low. The individual makes two arguments to demonstrate that the security risk related to a future episode is low. First, he argues that his medical history indicates that, with his current medication and stable lifestyle, he is only likely to have an episode once in every three or more years. Second, he argues that should an episode occur, he will recognize the symptoms and seek immediate treatment. He believes that such treatment significantly reduces the security risk arising from a future psychotic episode. For the reasons stated below, I accept these arguments and conclude that the evidence presented by the individual adequately mitigates the security concerns raised by his bipolar illness, now in full remission.

It is clear that the psychotic, manic bipolar episodes experienced by the individual in 1996, 1997 and 2004 pose a significant security risk to the DOE. In several Part 710 decisions, Hearing Officers have found that the risk of future, untreated Type I Bipolar episodes such as these poses too great a security risk to permit the granting of an access authorization. 2/ However, I

2/ *See Personnel Security Hearing (Case No. TSO-0031)*, 28 DOE ¶ 82,950 (2003) (possibility of relapse was too great for individual with Bipolar Affective Disorder to retain her access authorization); *Personnel Security Hearing (Case No. VSO-0358)*, 28 DOE ¶ 82,755 (2000) (possibility of relapse was too great for individual with Bipolar I Disorder to retain his access authorization); and *Personnel Security Hearing (Case No. VSO-0150)*, 26 DOE ¶ 82,789 (1997) *aff'd Personnel Security*

(continued...)

find that the individual has provided evidence of a medication and lifestyle regimen that has resulted in a very low frequency of psychotic episodes in recent years. He also has shown a history of cooperation in his treatment of this disorder, and has demonstrated that he has self-knowledge of his condition, and the medical and family support system in place that will minimize the risk of an untreated psychotic episode occurring in the future.

A. *Frequency of Recurrence*

I find that the individual has demonstrated by the testimony of his wife and his psychiatrist that he has been compliant in taking his prescribed medications. The testimony of these witnesses as well as his friend, his co-worker, and his daughter-in-law confirm that apart from the three brief psychotic, manic episodes leading to his hospitalizations in 1996, 1997 and 2004, the individual leads a normal, stable life and interacts in a positive way with his family, friends and co-workers. Furthermore, I am persuaded by the testimony of the individual and his wife that they are sincerely committed to a regulated life-style which will promote the individual's good health in the future. *See Personnel Security Hearing (TSO-0189)* 29 DOE ¶ 82,820 at 85,860-61 (2005). The testimony at the Hearing also supports the individual's assertion that since January 1997, a period of more than eight years, he has had only one psychotic episode, and that this most recent episode was almost two years ago.

The DOE-consultant Psychiatrist and the individual's psychiatrist disagree on whether the individual's use of an anti-depressant will reduce or increase the risk of future psychotic episodes. I agree with the individual's psychiatrist that the fact that the individual has experienced only one psychotic episode in the nine years during which the individual has taken his current anti-depressant indicates that this medication does not appear to significantly increase the rate of cycling of his psychotic episodes. In addition, the DOE-consultant Psychiatrist has acknowledged that medical opinion

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2/(...continued)
Review, Case No. VSA-0150, 27 DOE ¶ 83,002 (1997) (aff'd OSA 1998) (possibility of relapse was too great to allow an individual with Bipolar I Disorder to retain his access authorization).

differs on this issue. Finally, with regard to medication, the DOE-consultant Psychiatrist noted in his report to the DOE that the individual's current use of Depakote "should decrease the severity and the frequency of future episodes, should future episodes occur." DOE-consultant Psychiatrist's March 5, 2005 Report at 11.

I conclude that the individual has demonstrated that his medication and lifestyle have resulted in a low frequency of psychotic episodes since 1997 that is likely to continue in the future.

B. *Emergency Treatment*

With regard to the effective treatment of any future episodes, I find that the individual has corroborated his assertion that he consistently has acted in accordance with the guidance of his wife and his psychiatrist in seeking appropriate treatment, and that it is likely that he will continue to do so. He also has established that he is currently under medical treatment that will permit him to address the onset of psychotic symptoms on an emergency basis. The individual and his wife acknowledge that he suffers from bipolar disorder and are maintaining an ongoing therapeutic relationship with the individual's psychiatrist that specifically addresses his bipolar disorder. They have recently instituted a self-monitoring system by which the individual and his wife will assess and record his sleep and mood patterns, enabling them to identify an oncoming psychotic episode, and to promptly access emergency treatment. The DOE-consultant Psychiatrist agrees that the self-monitoring system that the individual, his wife and his psychiatrist have put into place will enhance the chance of detecting a future psychotic episode at an early stage. Accordingly, I find that the individual has demonstrated that his current self-assessment procedures and medical treatment regimen will permit him to receive early emergency treatment for his bipolar condition, thereby significantly reducing the risk of developing psychotic and manic behaviors.

Based on all of these considerations set forth above, I find that the individual has adequately mitigated the security concerns arising from his diagnosis of bipolar illness.

V. *CONCLUSION*

For the reasons set forth above, I find that the DOE properly invoked Criterion (h) in suspending the individual's access authorization. After considering all the relevant information, favorable or unfavorable, in a comprehensive and common-sense manner, I find that the evidence and arguments advanced by the

individual convince me that he has sufficiently mitigated the security concerns accompanying that criterion. In view of Criterion (h) and the record before me, I find that restoring the individual's access authorization would not endanger the common defense and would be clearly consistent with the national interest. It therefore is my conclusion that the individual's access authorization should be restored. The individual may seek review of this Decision by an Appeal Panel under the regulation set forth at 10 C.F.R. § 710.28.

Kent S. Woods
Hearing Officer
Office of Hearings and Appeals

Date: March 13, 2006